		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005520

Facility Name: MOUNT ST JOSEPH

Address: 24955 NORTH HIGHWAY 12 (Number) LAKE ZURICH (City) 60047 (Zip Code)

County: LAKE

Telephone Number: 847-438-5050 **Fax #** 847-719-1060

IDPA ID Number: 36-2639774001

Date of Initial License for Current Owners: 1947

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: DON LASCO **Telephone Number:** 847-438-5050

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/1/04 to 6/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 10/11/05

(Type or Print Name) GERTRUDE LaBARBERA

(Title) SUPERIOR

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	132	Intermediate/DD	132	48,180	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	43,692	741		44,433	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,692	741		44,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.22%

D. How many bed-hold days during this year were paid by the Department?
1,915 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1947

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/05 Fiscal Year: 6/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	131,439		7,059	138,498		138,498	(13,850)	124,648			1
2	Food Purchase		211,408		211,408		211,408	(21,141)	190,267			2
3	Housekeeping	249,727	18,176		267,903		267,903		267,903			3
4	Laundry	41,676	8,631		50,307		50,307		50,307			4
5	Heat and Other Utilities			234,460	234,460		234,460	(11,723)	222,737			5
6	Maintenance	198,750	49,965	449,194	697,909		697,909		697,909			6
7	Other (specify):* FARM	1,431		128	1,559		1,559	(1,559)				7
8	**TOTAL General Services**	623,023	288,180	690,841	1,602,044		1,602,044	(48,273)	1,553,771			8
	B. Health Care and Programs											
9	Medical Director	29,516			29,516		29,516		29,516			9
10	Nursing and Medical Records	2,148,007	44,522	39,165	2,231,694	(26,500)	2,205,194		2,205,194			10
10a	Therapy	194,463			194,463	(6,857)	187,606	(6,000)	181,606			10a
11	Activities											11
12	Social Services	50,277			50,277		50,277		50,277			12
13	CNA Training					26,500	26,500		26,500			13
14	Program Transportation		27,107		27,107		27,107		27,107			14
15	Other (specify):* DAY TRAINING	260,199	12,450	124,950	397,599		397,599	(397,599)				15
16	**TOTAL Health Care and Programs**	2,682,462	84,079	164,115	2,930,656	(6,857)	2,923,799	(403,599)	2,520,200			16
	C. General Administration											
17	Administrative	103,620	17,136		120,756		120,756		120,756			17
18	Directors Fees											18
19	Professional Services			64,051	64,051		64,051		64,051			19
20	Dues, Fees, Subscriptions & Promotions			18,481	18,481		18,481		18,481			20
21	Clerical & General Office Expenses	137,578	24,165	20,542	182,285		182,285		182,285			21
22	Employee Benefits & Payroll Taxes			550,324	550,324		550,324	(15,936)	534,388			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,421	2,421		2,421		2,421			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,378	81,378		81,378		81,378			26
27	Other (specify):*											27
28	**TOTAL General Administration**	241,198	41,301	737,197	1,019,696		1,019,696	(15,936)	1,003,760			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,546,683	413,560	1,592,153	5,552,396	(6,857)	5,545,539	(467,808)	5,077,731			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MOUNT ST JOSEPH #0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			311,196	311,196		311,196	26,656	337,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(213,600)	(33,600)			34
35	Rent-Equipment & Vehicles					6,857	6,857		6,857			35
36	Other (specify):*											36
37	**TOTAL Ownership**			491,196	491,196	6,857	498,053	(186,944)	311,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			349,984	349,984		349,984		349,984			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			349,984	349,984		349,984		349,984			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,546,683	413,560	2,433,333	6,393,576		6,393,576	(654,752)	5,738,824			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34,991)	L1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(33,600)	L 34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(54,353)	L 30		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,000)	L 10a		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(397,599)	L 15		22
23	Malpractice Insurance for Individuals	(15,835)	L 22		23
24	Bad Debt	(1,559)	L 7		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(101)	L 22		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,723)	L 5		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (555,761)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(98,991)	VII L14	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (98,991)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (654,752)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MOUNT ST JOSEPH

ID# 0005520

Report Period Beginning: 07/1/04

Ending: 6/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4	NON-PATIENT MEALS	(34,991)	L 1 & 2	4
5				5
6	RENTED FACILITY SPACE	(33,600)	L 34	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	DEPRECIATION	(54,353)	L 30	14
15				15
16				16
17	PRIEST STIPEND	(6,000)	L 10a	17
18				18
19				19
20				20
21				21
22				22
23	DAY TRAINING	(397,599)	L 15	23
24	PAYROLL TAX DAY TRAINING	(15,835)	L 22	24
25	FARM	(1,559)	L 7	25
26	PAYROLL TAX FARM	(101)	L 22	26
27				27
28	UTILITIES	(11,723)	L 5	28
29				29
30	**SUBTOTAL (A): (SUM OF LINES 1-29**	(555,761)		30
31				31
32				32
33				33
34	COSTS (SCHEDULE VII)	-98,991	VII L14	34
35				35
36	SUBTOTAL (B): sum of lines 31-35	-98,991		36
37	TOTAL ADJUSTMENTS (A) and (B)	-654,752	L 45	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,964,256)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	81,009	0	0	0	0	0	0	0	0	0	81,009	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(98,991)	0	0	0	0	0	0	0	0	0	(98,991)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(98,991)	0	0	0	0	0	0	0	0	0	(98,991)	45

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DAUGHTERS OF ST. MARY OF PROVIDENCE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ (180,000)	DAUGHTERS OF ST. MARY PF PROVIDENCE	100.00%	$	$ (180,000)	1
2	V	30	DEPRECIATION	81,009	DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%		81,009	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ (98,991)			$	$ * (98,991)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SR. SHARON WILLIAMS	SUPERIOR	C.E.O.			84	100.00	SALARY	$ 58,620	L 17 C 1	1
2	SR. MARGARET SCHISSLE	ADMINISTRATOR	TREASURER			84	100.00	SALARY	45,000	L 17 C 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,620		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A			N/A			$	$			$	1
2	"			"								2
3	"			"								3
4	"			"								4
5	N/A			N/A								5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2004 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	NOT FOR PR	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 147,565 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1,010 SQ FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HOME & FARM	160 ACRES OR	1935	$ 8,000	1
2		6,969,600 SQ FEET			2
3	TOTALS	#VALUE!		$ 8,000	3

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132			1969	$ 5,007,009	$		$	$	$ 5,007,009	4
5											5
6				1990	2,361,653	78,720	30	78,720		1,220,162	6
7				1990	68,729	2,290	30	2,290		35,495	7
8											8
	Improvement Type**										
9	LAND IMPROVEMENT-PRIOR YEARS			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16				2001	4,700	16,427		16,427		213,929	16
17											17
18	BUILDING IMPROVEMENTS-PRIOR YEARS			1991	74,205						18
19				1992	90,293						19
20				1993	180,181						20
21				1994	178,251						21
22				1995	231,228						22
23				1996	82,875						23
24				1997	71,814						24
25				1998	116,448						25
26				1999	121,823						26
27				2000	37,015						27
28				2001	76,812	203,387		203,387		1,168,887	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,970,171	$ 300,824		$ 300,824	$	$ 7,645,482	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,970,171	$ 300,824		$ 300,824	$	$ 7,645,482	1
2	BUILDING IMPROVEMENTS 2001/2002								2
3	ROOF REPAIR	1-Jul	10,036						3
4	REPAIR SEWER LINE	1-Sep	23,771						4
5	REPAIR OF MUDRING TANK	1-Sep	2,170						5
6	A/C COMPRESSOR & CHILLER	1-Oct	12,700						6
7	DOOR REPLACEMENT	1-Oct	6,730						7
8	SUBMERSIBLE WELL PUMP	1-Oct	11,995						8
9	PLUMBING WORK	1-Dec	27,162						9
10	SPEED CONTROL REPLACEMENT	2-Apr	3,722						10
11	PLUMBING WORK	2-May	4,500						11
12	POOL LIGHTING	2-May	5,800						12
13	REPAIR DAMAGED DRY SYSTEM PIPE	2-Jun	3,500						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,082,257	$ 300,824		$ 300,824	$	$ 7,645,482	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,082,257	$ 300,824		$ 300,824	$	$ 7,645,482	1
2	BUILDING IMPROVEMENTS 2002-2003								2
3	AUTOMATIC TANK GUAGING SYSTEM	2-Jul	13,167						3
4	CARLSON HALL STEAM LINE	2-Jul	1,913						4
5	CLEAN STEAM BOILERS	2-Nov	4,740						5
6	2 UNIT HEATERS IN GARAGE	2-Dec	6,145						6
7	HOT WATER HEATER/ANGEL GUARDIAN	2-Dec	9,084						7
8	PENTAIT HEATER/POOL	2-Oct	5,481						8
9	THERAPY CENTER ROOF WORK	3-May	2,100						9
10	TWO REST ROOMS	3-Jan	32,000						10
11	REPLACE RADIANT IN BASEMENT	3-Feb	3,633						11
12	REPAIR SEWER IN CRAWL SPACE	3-Mar	4,714						12
13	ARCHITECTURAL PLANS	3-Apr	2,640						13
14	F;OOR PANELS/KITCHEN	3-May	12,830						14
15	SPEED CONTROL/THERAPY	3-Jun	5,728						15
16	TRANSRER LIFT/THERAPY	3-Jun	6,448						16
17	AIR CONDITIONING/ADMIN	3-Jun	124,900						17
18	AIR CONDITIONING/WIRING	3-Jun	14,600						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,332,380	$ 300,824		$ 300,824	$	$ 7,645,482	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,332,380	$ 300,824		$ 300,824	$	$ 7,645,482	1
2	BUILDING IMPROVEMENTS 2003-2004								2
3	WALK IN COOLER/KITCHEN	3-Sep	6,190						3
4	AIR CONDITIONER/NOVIATE	3-Oct	105,000						4
5	AIR CONDITIONER UNITS	3-Oct	1,800						5
6	FIRE ALARM ANGEL GUARDIAN	3-Nov	4,800						6
7	SUBMERSIBLE PUMP	3-Nov	2,196						7
8	AIR COMPRESSOR	3-Dec	4,955						8
9	DRAIN,WATER CLOSET,SEWER/KITCHEN	3-Dec	12,567						9
10	CONDESATE PUMP/ANGELINA	4-Jan	2,989						10
11	FIRE DOOR/SACRED HEART	4-Jan	3,448						11
12	NEW ROOF/GUANELLA HALL	4-Jan	36,237						12
13	AUTOMATIC DOOR/KITCHEN	4-Feb	8,032						13
14	2 COOLERS/KITCHEN	4-Mar	30,000						14
15	WALK IN UNITS/KITCHEN	4-Mar	54,160						15
16	AUTOMATIC DOOR/THERAPY	4-Apr	6,736						16
17	GAS LINE/KITCHEN	4-Apr	3,708						17
18	AIR COMPRESSOR	4-May	1,809						18
19	AIR CONDITIONER/SACRED HEART	4-May	6,300						19
20	AIR CONDITIONER/ADMIN	4-May	12,290						20
21	HOT WATER LINE/MARCELLINA	4-Jun	4,273						21
22	COOLER WIRING/KITCHEN	4-Jun	1,890						22
23	TEST BALANCE/KITCHEN	4-Jun	18,820						23
24	AIR CONDITIONER/ADMIN	4-Jun	4,446						24
25	AIR CONDITIONER/KITCHEN	4-Jun	11,794						25
26	WALK IN COOLER/KITCHEN	4-Jun	45,000						26
27	CONTROL VALVES/CRAWL SPACE	4-Jun	3,659						27
28	FREEZER COOLER WIRING/KITCHEN	4-Jun	9,000						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,734,479	$ 300,824		$ 300,824	$	$ 7,645,482	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,734,479	$ 300,824		$ 300,824	$	$ 7,645,482	1
2	BUILDING IMPROVEMENTS 2004-2005								2
3	KITCHEN DRAIN LINE	4-Aug	3,901						3
4	CARPET/ADMIN	4-Aug	15,502						4
5	AIR CONDITIONER/ADMIN	4-Aug	5,112						5
6									6
7	INSPECT & CLEAN BOILERS	4-Sep	4,227						7
8	MOP SINK/ADMIN	4-Sep	3,630						8
9	ELECTRICAL WORK/VILLA	4-Sep	16,000						9
10	REMODEL COOLER/KITCHEN	4-Sep	51,662						10
11	BOILER ROOM ROOF	4-Sep	23,741						11
12	ARCHITECTURAL SERVICE/KITCHEN	4-Sep	4,500						12
13	WALK IN UNITS/KITCHEN	4-Sep	12,105						13
14	REPLACE SEWER LINE/ST. MARY	4-Oct	15,740						14
15	GARAGE DOOR	4-Oct	4,312						15
16	EXHAUST FAN/ADMIN	4-Nov	2,945						16
17	WELL WATER PUMP	4-Nov	9,968						17
18	PERMIT FEE/KITCHEN	4-Dec	2,332						18
19									19
20	WATER COIL/ADMIN	4-Dec	7,940						20
21	REPAIRS/RECTORY BLDG.	4-Dec	18,588						21
22	REPAIR WATER MAIN	5-Jan	32,076						22
23	AIR COMPRESSOR	5-Jan	10,651						23
24	REPAIR GENERATOR	5-Feb	1,880						24
25									25
26	ELECTRICAL WORK THERAPY	5-Feb	12,405						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,993,696	$ 300,824		$ 300,824	$	$ 7,645,482	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,993,696	$ 300,824		$ 300,824	$	$ 7,645,482	1
2	LAND IMPROVEMENT 2005								2
3	TREE SERVICE	5-Mar	3,300						3
4	TREE SERVICE	5-Jun	2,400						4
5									5
6	BUILDING IMPROVEMENTS 2005								6
7	ROOF HOUSE & GARAGE/PRIEST	5-Feb	19,714						7
8	LIGHT POLE/ADMIN	5-Feb	2,600						8
9	ELECTRICAL WORK/ADMIN	5-Mar	2,480						9
10	MASONRY & DRYWALL/ADMIN	5-Mar	29,840						10
11	LAMINATE CABINETS/KITCHEN	5-Mar	15,380						11
12	CABINETS/CHAPEL	5-Mar	2,800						12
13	HEAT EXCHANGER/ADMIN	5-Apr	7,000						13
14	SINK/KITCHEN	5-Apr	4,740						14
15	ROOF/THERAPY	5-May	10,859						15
16	DUMB WAITER/KITCHEN	5-Jun	2,464						16
17	REPAIRS & PAINT/ADMIN	5-Jun	14,433						17
18	WATER PIPE/ADMIN	5-Jun	9,334						18
19	ELECTRIC & SEPTIC/BARN	5-Jun	7,200						19
20	ROOF REPAIR/ST. AL,S	5-Jun	10,000						20
21	HEATING UNIT/KITCHEN	5-Jun	3,200						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,141,440	$ 300,824		$ 300,824	$	$ 7,645,482	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,177,875	$ 34,694	$ 34,694	$		$ 1,098,615	71
72	Current Year Purchases	21,717						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,199,592	$ 34,694	$ 34,694	$		$ 1,098,615	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	2002 FORD VAN	2002	$ 23,334	$ 2,334	$ 2,334	$	10	$ 9,336	76
77										77
78										78
79										79
80	TOTALS			$ 23,334	$ 2,334	$ 2,334	$		$ 9,336	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,372,366	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 337,852	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 337,852	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,753,433	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	$ 40,316	$	$ 40,316	86
87	VEHICLES	464,674	23,052	322,195	87
88	NON-CARE	1,052,810	31,301	895,859	88
89					89
90					90
91	TOTALS	$ 1,557,800	$ 54,353	$ 1,258,370	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,857 Description: COPY MACHINES LEASE
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	10,900	5,200		16,100
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		10,400		10,400
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 10,900	$ 15,600	$	$ 26,500
10	SUM OF line 9, col. 1 and 2	(e)	$ 26,500			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	19

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9/1	visits	29,516					29,516	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 29,516		$	$		$ 29,516	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,443,588	$ 1,443,588	1
2	Cash-Patient Deposits	87,909	87,909	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	856,321	856,321	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	52,541	52,541	5
6	Prepaid Insurance	42,645	42,645	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,483,004	$ 2,483,004	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	1,735,637	3,926,975	15
16	Equipment, at Historical Cost		2,780,726	16
17	Accumulated Depreciation (book methods)		(8,807,786)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,735,637	$ 5,345,306	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,218,641	$ 7,828,310	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 89,725	$ 89,725	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	107,247	107,247	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	372,684	372,684	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 569,656	$ 569,656	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 569,656	$ 569,656	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,648,985	$ 7,258,654	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,218,641	$ 7,828,310	48

***(See instructions.)**

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,435,371	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,435,371	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	213,614	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 213,614	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,648,985	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,702,388	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,702,388	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	19,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,200	23
	D. Non-Operating Revenue		
24	Contributions	411,326	24
25	Interest and Other Investment Income***	14,337	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 425,663	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DEVELOPMENTAL TRAINING	459,939	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 459,939	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,607,190	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,602,044	31
32	Health Care	2,930,656	32
33	General Administration	1,019,696	33
	B. Capital Expense		
34	Ownership	491,196	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	349,984	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,393,576	40
41	**Income before Income Taxes (line 30 minus line 40)****	213,614	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 213,614	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,616	35,813	499,593	13.95	3
4	Licensed Practical Nurses	7,049	7,242	92,697	12.80	4
5	CNAs & Orderlies	2,300	2,366	23,660	10.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,903	6,098	67,567	11.08	9
10	Activity Assistants	10,082	10,232	80,321	7.85	10
11	Social Service Workers	3,147	3,345	50,277	15.03	11
12	Dietician					12
13	Food Service Supervisor	4,500	4,617	46,170	10.00	13
14	Head Cook	3,274	3,374	25,477	7.55	14
15	Cook Helpers/Assistants	8,576	8,691	59,792	6.88	15
16	Dishwashers	20,549	20,849	260,199	12.48	16
17	Maintenance Workers	21,046	21,144	198,750	9.40	17
18	Housekeepers	29,457	29,907	249,727	8.35	18
19	Laundry	5,347	5,427	41,676	7.68	19
20	Administrator	3,981	4,021	58,620	14.58	20
21	Assistant Administrator	4,308	4,348	45,000	10.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,684	11,984	137,578	11.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,699	1,724	29,516	17.12	27
28	Qualified MR Prof. (QMRP)	12,374	12,499	144,066	11.53	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	76,152	77,852	1,420,794	18.25	30
31	Medical Records	941	986	13,772	13.97	31
32	Other Health Care(specify)					32
33	Other(specify) FARM	150	156	1,431	9.17	33
34	TOTAL (lines 1 - 33)	268,135	272,675	$ 3,546,683 *	$ 13.01	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	128	$ 7,059	L 1 C 3	35
36	Medical Director				36
37	Medical Records Consultant	105	4,200	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	76	4,068	L 10 C 3	40
41	Occupational Therapy Consultant	60	3,450	L 10 C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) PSYCHOLOGY	250	13,769	L 10 C 3	46
47	DENTIST	233	11,638	L 10 C 3	47
48	PODIATRIST	34	2,040	L 10 C 3	48
49	TOTAL (lines 35 - 48)	886	$ 46,224		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHARON WILLIAMS	SUPERIOR		$ 58,620
MARGARET SCHISSLER	ADMINISTRATOR		45,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,620

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FOLISI SAMZ	AUDITORS	$ 33,465
DAVID BIXLER	AUDITORS	4,030
RONALD GRIMES	AUDITORS	8,610
A.D.P.	PAYROLL	16,922
CREMER, KOPON	LEGAL	1,024
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 64,051

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,332
Unemployment Compensation Insurance	
FICA Taxes	282,020
Employee Health Insurance	89,034
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	103,938
TOTAL (agree to Schedule V, line 22, col.8)	$ 550,324

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,509
Health Care Worker Background Check	
(Indicate # of checks performed)	
LICENSE & FEES	7,071
DUES & SUBSCRIPTIONS	2,701
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,481

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,421
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,421

**See instructions.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/1/04 Ending: 6/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MOUNT ST JOSEPH **#** 0005520 **Report Period Beginning:** 07/1/04 **Ending:** 6/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,906** Line **L 10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **349,984**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **17,043**
c. What percent of all travel expense relates to transportation of nurses and patients? **10 %**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **FOLISI,SAMZ & COMPANY** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **LESS THEN $2,500**
Attach invoices and a summary of services for all architect and appraisal fees.

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM V. LINE 10		-26,500
TO V. LINE 13		26,500
RECLASSIFY NURSE AIDE TRAINING		
FROM V. LINE 10a		-6,857
TO V. LINE 35		6,857
RECLASSIFY RENT-EQUIPMENT		

V. COST CENTER EXPENSES OTHER LINE 7 PAGE 3

FARM	SALARIES		1,431
	OTHER/BENEFITS		128
	PAYROLL TAXES		101
	TOTAL		1,660

V. COST CENTER EXPENSES OTHER LINE 15 PAGE 3

DAY TRAINING	SALARIES		260,199
DAY TRAINING	SUPPLIES		12,450
DAY TRAINING	BENEFITS	19,907	
	OCCUPANCY	40,892	
	TRANSPORT	57,176	
	RENT	2,556	
	DEPRECIATION	4,419	124,950
DAY TRAINING	P/R TAXES		15,835
	TOTAL		413,434

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES			
DIETARY	V. LINE 1 138,498 X .10 =	-13,850	
FOOD PURCHASE	V. LINE 2 211,408 X .10 =	-21,141	-34,991
RENTED SPACE	V. LINE 34		-33,600
DEPRECIATION	V. LINE 30		-54,353
PRIEST STIPEND	V. LINE 10a		-6,000
DAY TRAINING	V. LINE 15		-397,599
P/R TAX D/T	V. LINE 22		-15,835
FARM	V. LINE 22		-1,559
P/R TAX FARM	V. LINE 22		-101
UTILITIES	V. LINE 5		-11,723
SUBTOTAL (A):			-555,761
COSTS	VIL. LINE 14		-98,991
SUBTOTA (B):			-98,991
TOTAL ADJUSTMENTS			-654,752

VI. ADJUSTMENT DETAIL/UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREAS:

THERAPEUTIC CENTER		29,459
NURSES STATION TO KITCHEN PASSAGEWAY		6,770
ADMINISTRATIVE BUILDING		6,890
NOVITIATE & AUDITORIUM		11,120
ANGEL GUARDIAN		9,582
BOILER & LAUNDRY		4,690
CHAPEL		12,468
GARAGE		1,012
ST. MARY,S		11,691
JOSEPH,S		9,464
PASSAGEWAY		5,392
ST. ALOYIOUS		9,270
GUANELLA		15,887
KITCHEN		5,749
GARAGE		660
CHAPLAIN,S HOUSE		4,022
ADMINISTRATIVE BUILDING 2nd FLOOR		3,445
	TOTAL	147,562

NON-CARE RELATED AREAS:

NOVITIATE & AUDITORIUM		5,560
FARM HOUSE		1,768
	TOTAL	7,328

TOTAL SQUARE FOOTAGE	154,890
NON-CARE AREAS 7,328/154,890	X =.05
TOTAL UTILITIES LINE 5 PAGE 3	234,460
	X.05
TOTAL NON-CARE RELATED UTILITIES	11,723

XVIL. INCOME STATEMENT / OTHER REVENUE PAGE 19

DEVELOPMENTAL TRAINING LINE 28a	459,939

XVIII. A. STAFFING AND SALARY COSTS PAGE 20

DEVELOPMENTAL TRAINING	LINE 16	260,199
PSYCHOLOGY	LINE 31	13,772
FARM	LINE 33	1,431

XX. GENERAL INFORMATION: PAGE 23

COST ASSOCIATED WITH SPACE RENTA LINE 14
NUNS QUARTERS